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Notes

Refusing Life-Sustaining Treatment: Can We Just Say No?

I. INTRODUCTION

Two things in life are certain: death and taxes. This Note is not about taxes. Everyone dies. Some die suddenly and unexpectedly; for others, death is expected, and it comes after its victim has had time to reflect on life and prepare for death. Americans are increasingly concerned with decisions about death and dying. In particular, the choice between dying or existing in an unconscious state with no hope of recovery has caused many Americans to document their wishes.

In 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (the Commission) published a report which examined the situations in which a patient's choice to refuse life-sustaining treatment may be limited on moral or legal grounds.¹ In addition to clarifying the moral and legal issues, this report suggested appropriate procedures for competent and incompetent patients to make medical treatment decisions. The report also discusses the role that particular public and private agencies should play in creating and regulating these procedures.²

One of the Commission's conclusions was that

state courts and legislatures should consider making provision for advance directives through which people designate others to make health care decisions on their behalf and/or give instructions about their care. Such advance directives provide a means of preserving some self-determination for patients who

1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS (U.S.G.P.O. Mar. 1983)[hereinafter PRESIDENT'S COMMISSION REPORT].

2 *Id.* at 2.

may lose their decisionmaking capacity. Durable powers of attorney are preferable to "living wills" since they are more generally applicable and provide a better vehicle for patients to exercise self-determination, though experience with both is limited.³

At the time of the Commission's report few states had statutes which provided for advance directives.⁴ Following the Commission's report, many state legislatures responded by adopting living will statutes.⁵ This flurry of legislation, in turn, provoked much scholarly criticism.⁶

The legal issues involved with refusal of medical treatment, discontinuation of medical treatment, living wills, and health care powers of attorney have become popularly known as "right to die" issues.⁷ Right to die issues are very complex, in part because this area of law has evolved, and continues to evolve, out of legal antecedents which are logically in tension with one another.

The most basic of these legal antecedents is the law of battery. The law of battery protects individuals from nonconsensual bodily contact, which includes unauthorized medical procedures.⁸ This doctrine has produced a legal right not to be treated without consent, and a requirement that the consent be informed. The

3 *Id.* at 5.

4 The first statute of this nature, the California Natural Death Act, was adopted in 1976. See CAL. HEALTH & SAFETY CODE § 7185 (West Supp. 1992). Between 1976 and 1979, nine states in addition to California, enacted living will laws. Between 1981 and 1984 twelve other states enacted similar laws. See SOCIETY FOR THE RIGHT TO DIE, *HANDBOOK OF 1985 LIVING WILL LAWS* 5 (1986) [hereinafter 1985 LIVING WILL LAWS].

5 "Living will statute" is used as a generic term for the statutes that authorize living wills. States call them natural death acts, death with dignity acts, or rights of the terminally ill acts. From March 4 to July 1, 1985, thirteen states adopted living will statutes. 1985 LIVING WILL LAWS, *supra* note 4, at 5.

6 See, e.g., Carol Ann Mooney, *Indiana's Living Wills and Life-Prolonging Procedures Act: A Reform Proposal*, 20 IND. L. REV. 539 (1987); Joseph P. Baumann, Jr., Note, *The Right to Die in New Jersey: Another Plea For Legislation*, 18 RUTGERS L.J. 235 (1986); Gina K. Grimes, Note, *Changing Attitudes in Florida's "Right to Die" Law*, 14 STETSON L. REV. 375 (1985); Barbara Miltenberger, Comment, *The Dilemma of The Person In A Persistent Vegetative State: A Plea To The Legislature For Help*, 54 MO. L. REV. 645 (1989); Karen M. Moran, Note, *The Conflict Continues: Who Decides Treatment Questions For The Terminally-Ill Incompetent Patient?*, 18 SUFFOLK U. L. REV. 641 (1984); Melinda H. Organ, Comment, *Withholding Life-Sustaining Treatment From The Incompetent Patient: The Need For Statutory Guidelines*, 17 LOY. U. CHI. L.J. 427 (1986).

7 This label comes from early judicial opinions in this area. See, e.g., John F. Kennedy Memorial Hosp. v. Bludworth, 432 So. 2d 611 (Fla. Dist. Ct. App. 1983); In re Quinlan, 348 A.2d 801 (N.J. Super. 1975). The term "right to die" usually applies when an individual's decision is likely to cause the patient's death.

8 See *infra* notes 58-59 and accompanying text.

informed consent requirement has evolved into an affirmative right to refuse medical treatment.⁹

The right to refuse treatment theoretically conflicts with the principles of criminal law.¹⁰ While the law of battery has spawned the right to refuse medical treatment, criminal law principles limit this right when an individual's decisions lead to the individual's death.

In addition, the right to die raises both substantive and procedural issues. The central procedural question is at what point, if any, must medical decision-making get judicial approval;¹¹ this Note does not address procedural issues.¹² The central substantive issue is which patients are permitted to refuse treatment, and which patients are required to accept treatment;¹³ this Note engages the substantive issue.

The purpose of this Note is to urge state lawmakers to reevaluate their right to die legislation, and to suggest some substantive issues that they should address. Part II reviews the bases of the right to die.¹⁴ Part III examines modern "right to die" legislation. Part IV is an analysis of the legislative efforts of selected states and seeks to show ambiguities and inconsistencies that should be cured by remedial legislation.

II. BASES FOR THE RIGHT TO REFUSE MEDICAL TREATMENT

Traditionally, courts have based the right to refuse medical treatment on the constitutional right to privacy,¹⁵ common law

9 See ALAN MEISEL, *THE RIGHT TO DIE* 13 (1989).

10 See *In re Colyer*, 660 P.2d 738, 751 (Wash. 1983) ("Under Washington's criminal code, homicide is 'the killing of a human being by the act, procurement or omission of another,' . . . and it is murder in the first degree when, '[w]ith premeditated intent to cause the death of another person, [one] causes the death of such person.' Thus, the potential for criminal liability for withdrawing life sustaining mechanisms appears to exist.") (emphasis added).

11 MEISEL, *supra* note 9, at 6.

12 For a thorough discussion of the procedural issues associated with the right to die, see *Id.* at 145.

13 *Id.* at 5.

14 Although the right to die is the common label given to this area of law, the author will refer to it as the right to refuse medical treatment hereafter. This area of law is evolving; the suggestions and analysis in this Note should not be confused as an endorsement of more controversial issues such as active euthanasia.

15 See *Severns v. Wilmington Medical Ctr., Inc.*, 421 A.2d 1334 (Del. 1980); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977); *In re Quinlan*, 355 A.2d 647 (N.J. 1976); *Leach v. Akron Gen. Medical Ctr.*, 68 Ohio Misc. 1 (C.P. P. Div. 1980); *In re Colyer*, 660 P.2d 738 (Wash. 1983).

rights,¹⁶ or a state statute.¹⁷ The lack of differentiation among the bases of this right is the result of the courts' view that its scope does not depend upon which basis the court relies upon for the source of the right. However, a right to refuse medical treatment based on a constitutional right is a stronger right than one based on common law principles.¹⁸ This Part surveys each basis for the right to refuse medical treatment and considers cases that have upheld the right on each basis.

A. *The Constitutional Right of Privacy*

Some litigants have asserted that their right to refuse medical treatment is based on the United States Constitution. In most cases the litigants claim that the right to refuse medical treatment arises out of the constitutional right of privacy, but occasionally litigants assert other constitutional sources.¹⁹

The United States Supreme Court identified a general right of privacy in *Griswold v. Connecticut*.²⁰ Although the Court has never addressed the question of whether the right to refuse medical treatment is included in the right to privacy, the Court has said that the freedom to care for one's health and person is protected by the right to privacy.²¹ Interpreting these words, some state courts have held that a terminally ill adult has a constitutionally protected right to refuse life-sustaining treatment.²²

16 See, e.g., *Eichner v. Dillon*, 420 N.E.2d 64 (N.Y. 1980). See *infra* notes 64-75 and accompanying text.

17 *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Cal. Ct. App. 1983). See *infra* notes 118-139 and accompanying text.

18 *Id.* at 540-41 ("Common-law rights can be abrogated by statute in the exercise of the State's police powers subject only to due process requirements . . . Constitutional rights on the other hand cannot be so abrogated.").

19 See, e.g., *In re Quinlan*, 355 A.2d 647 (N.J. 1976) (free exercise of religion, and right to be free of cruel and unusual punishment).

20 381 U.S. 479 (1965). In *Griswold*, the United States Supreme Court invalidated a Connecticut statute because it restricted the right of married persons to use contraceptive devices. *Id.* The majority opinion struggled to find a textual basis for the right of privacy; the constitutional basis Justice Douglas relied on for this new right was the penumbras and emanations of several guarantees in the Bill of Rights. JOHN E. NOWAK ET AL., CONSTITUTIONAL LAW 686-87 (1986). We can only determine the scope of the right of privacy by examining subsequent cases. See, e.g., *Zablocki v. Redhail*, 434 U.S. 374 (1978); *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977); *Roe v. Wade*, 410 U.S. 113 (1973); *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

21 See *Doe v. Bolton*, 410 U.S. 179, 213 (1973) (Douglas, J., concurring).

22 See, e.g., *Severns v. Wilmington Medical Ctr., Inc.*, 421 A.2d 1334, 1347 (Del. 1980); *Superintendent of Bilchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 424 (Mass. 1977); *Quinlan*, 355 A.2d at 663; *Leach v. Akron Gen. Medical Ctr.*, 68 Ohio Misc. 1

1. In re Quinlan²³

Karen Ann Quinlan suffered severe neurological damage which left her in a persistent vegetative state.²⁴ Medical experts concluded that she had no reasonable chance of regaining consciousness;²⁵ a mechanical respirator kept her alive by sustaining her respiratory functions.²⁶ Joseph Quinlan, Karen's father, initiated guardianship proceedings to have Karen adjudicated incompetent and to have himself appointed as her guardian.²⁷ Moreover, Mr. Quinlan sought specific power, as her guardian, to authorize the discontinuance of mechanical life-support.²⁸

Mr. Quinlan presented three constitutional arguments to obtain authorization to discontinue Karen's treatment. The first two—that forced continuation of medical treatment violated the right to free exercise of religion and constituted cruel and unusual punishment—were quickly disposed of.²⁹

Mr. Quinlan's third argument was that Karen had a privacy right to refuse further treatment.³⁰ The court found that the constitutional right of privacy, found in both the state and federal

(CP. P. Div. 1980); In re Colyer, 660 P.2d 738, 741-42 (Wash. 1983).

23 355 A.2d 647 (N.J. 1976).

24 *Id.* at 653-54. A persistent vegetative state is a state where the "subject . . . remains with the capacity to maintain the vegetative parts of the neurological function but who . . . no longer has any cognitive function." *Id.* at 654.

25 *Id.* at 654.

26 *Id.* at 655.

27 *Id.* at 651. These proceedings were initiated after Karen's doctor refused Mr. Quinlan's request to have Karen's respirator disconnected. *Id.* at 656.

28 *Id.* at 651.

29 Mr. Quinlan asserted that forced continuation of Karen's treatment violated both Karen's and his constitutional right to the free exercise of religion. *Id.* at 661. Mr. Quinlan asserted, derivatively, Karen's constitutional rights and his own independent rights as Karen's father. *Id.* at 660. The court "simply stated, the right to religious beliefs is absolute but conduct in pursuance thereof is not wholly immune from governmental restraint." *Id.* at 661. The court concluded "that, ranged against the state's interest in the preservation of life, the impingement of religious belief, . . . , does not reflect a constitutional question, in the circumstances at least of the case presently before the [c]ourt." *Id.* The court did not "recognize an independent parental right of religious freedom to support the relief requested." *Id.* at 661-62.

Mr. Quinlan also asserted that continuation of treatment was tantamount to cruel and unusual punishment. The court noted that the Eighth Amendment protection "is not relevant to situations other than the imposition of penal sanctions." *Id.* at 662. The court found that the conditions inflicted upon Karen by fate and nature, not the state nor the law, were cruel and most unusual, "yet [they] do not amount to 'punishment' in any constitutional sense." *Id.*

30 *Id.* at 664.

constitutions, is broad enough to encompass an individual's decision to refuse medical treatment.³¹ To preserve Karen's ability to exercise her right despite her condition, the court authorized Karen's guardian, her father Joseph Quinlan, to substitute his best judgment as to whether Karen would exercise her right to refuse this treatment if she was competent to do so.³² The court decided that the best way to protect Karen's constitutional rights was to allow her guardian to exercise "substituted judgment."³³

The New Jersey Supreme Court felt that these types of decisions should be made by the patient's family, the patient's doctor, and reviewed by the hospital ethics committee, if the hospital has one.³⁴ To require judicial approval for treatment decisions would be cumbersome and an inappropriate interference with the medical profession.³⁵

2. Superintendent of Belchertown State School v. Saikewicz³⁶

The Massachusetts Supreme Judicial Court agreed with the *Quinlan* court to the extent that the constitutional right to privacy includes the right to individual free choice and self-determination, and that self-determination included the right of both competent and incompetent patients to refuse medical treatment.³⁷ However, the Massachusetts court rejected the approach in *Quinlan* and held that judicial authorization is required before the patient's family or doctor could discontinue the medical treatment of an incompetent patient.³⁸

The *Saikewicz* court required that an adversarial judicial proceeding be conducted to protect the rights of a patient that has

31 *Id.* at 663.

32 *Id.* at 664. The court concluded that Karen's rights could be asserted on her behalf by her father; the court also concluded that there is no parental constitutional right that would entitle him to discontinue Karen's treatment on its own. *Id.*

33 *Id.* Substituted judgment is one approach to determining what health care decisions an incompetent patient would make if the patient was competent. A surrogate decision maker is required to make the decision for an incompetent patient based on the subjective preferences the patient expressed before becoming incompetent. See MEISEL, *supra* note 9, at 267. For a critical analysis of the doctrine of substituted judgment and surrogate decisionmaking, see Michele Yuen, Comment, *Letting Daddy Die: Adopting New Standards For Surrogate Decisionmaking*, 39 UCLA L. REV. 581 (1992).

34 *Quinlan*, 355 A.2d at 668-69.

35 *Id.* at 669.

36 370 N.E.2d 417 (Mass. 1977).

37 *Id.* at 424.

38 *Id.* at 434-35.

been adjudicated incompetent.³⁹ The court would appoint a guardian ad litem to argue the position opposite of the petitioner's.⁴⁰ The court would consider the factors that a competent patient would consider under these conditions, and determine which choice the incompetent patient would have made if they were competent. The court would substitute its judgment for the judgment of the incompetent patient.⁴¹

The differences between the courts' approaches have generated several questions. The *Quinlan* court decided that judicial intervention in these cases is unwise;⁴² the *Saikewicz* court determined that judicial intervention is the best way to protect the patient's interests.⁴³ Writers disagree about what is the proper role for the judiciary in these cases.⁴⁴

3. *Cruzan v. Director, Missouri Department of Health*⁴⁵

Recently, the United States Supreme Court faced issues concerning an individual's right to refuse medical treatment. The Missouri Supreme Court established a procedural safeguard which requires clear and convincing evidence that an incompetent patient would choose to discontinue medical treatment before treatment could be discontinued. The primary issue in *Cruzan* was whether this requirement was an unconstitutional procedural obstacle to the exercise of a fundamental right.⁴⁶ The Court held that it was constitutional for Missouri to require a heightened evidentiary standard where a guardian of a person in a persistently vegetative state sought to discontinue artificial nutrition and hydration to that person.⁴⁷

39 *Id.* at 433.

40 *Id.*

41 *Id.* at 434.

42 See *supra* notes 33-35 and accompanying text.

43 See *supra* note 38 and accompanying text.

44 Compare Arnold S. Relman, *The Saikewicz Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233 (1978) (arguing that lengthy court proceedings may unnecessarily prolong the life and suffering of an incompetent patient) with Charles H. Baron, *Medical Paternalism And The Rule of Laws: A Reply To Dr. Relman*, 4 AM. J.L. & MED. 337 (1979) (suggesting that a physician should do anything possible to prolong the life of a patient, and only terminate treatment after judicial authorization has been granted).

45 110 S.Ct. 2841 (1990).

46 *Id.* at 2851. For the purposes of this case, the Court assumed that a competent person had a constitutionally protected right to refuse lifesaving hydration and nutrition. *Id.* at 2852.

47 *Id.* at 2851-52.

Although the majority did not announce a constitutionally protected right to refuse medical treatment in *Cruzan*, strong language in Justice O'Connor's concurring opinion may signify that the Court will recognize this right in the future.⁴⁸ Justice O'Connor wrote separately to emphasize that the Court did not consider this question;⁴⁹ she stated that in her view, the state may "be constitutionally required to protect the patient's liberty interest in refusing medical treatment."⁵⁰

B. Common Law Rights

State courts have given the common law right to be free from physical invasions of bodily integrity many different labels. This right is protected through the doctrine of informed consent⁵¹ and is often referred to as a right of privacy,⁵² self-determinism,⁵³ a right to control one's own body,⁵⁴ or autonomy.⁵⁵

The first case to recognize the right of bodily self-determinism was *Union Pacific Railway v. Botsford*.⁵⁶ The Supreme Court stated, "[n]o right is . . . more carefully guarded, by the common law, than the right of every individual to . . . control his own person."⁵⁷ The most commonly quoted source of the common law right to refuse medical treatment is *Scholendorff v. Society of New York Hospitals*.⁵⁸ In his now famous opinion, Justice Cardozo stated, "[e]very human being of adult years and sound mind has the right to determine what shall be done with his own body; and a

48 *Id.* at 2858 ("[t]oday's decision, . . . does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate.").

49 *Id.* at 2857.

50 *Id.*

51 Organ, *supra* note 6, at 430.

52 See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 301 (Cal. Ct. App. 1986); *In re Quinlan*, 355 A.2d 647, 662 (N.J. 1976).

53 See *In re Gardner*, 534 A.2d 947, 950 (Me. 1987); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 633 (Mass. 1986); *In re Jobes*, 529 A.2d 434, 436 (N.J. 1987); *In re Farrell*, 529 A.2d 404, 410 (N.J. 1987); *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985).

54 See *Bouvia*, 225 Cal. Rptr. at 300; *Conroy*, 486 A.2d at 1221; *Farrell*, 529 A.2d at 410; *Eichner v. Dillon*, 420 N.E.2d 64, 70 (N.Y. 1981).

55 MEISEL, *supra* note 9, at 50-51.

56 141 U.S. 250 (1891).

57 *Id.* at 251.

58 105 N.E. 92 (N.Y. 1914).

surgeon who performs an operation without his patient's consent commits an assault.⁵⁹

Traditionally, the remedy for violating a person's right to refuse medical treatment has been a cause of action for assault or battery.⁶⁰ Other potential remedies include tort actions for the intentional infliction of emotional distress,⁶¹ negligent infliction of emotional distress,⁶² and invasion of privacy.⁶³

1. *In re Eichner*⁶⁴

The New York Court of Appeals held that prior judicial authorization for the discontinuance of medical treatment from terminally ill patients is not mandatory.⁶⁵ Brother Joseph Fox suffered cardiac arrest during a hernia operation.⁶⁶ The cardiac arrest resulted in substantial brain damage; Brother Fox could not breathe spontaneously, and was put on a respirator which maintained him in a vegetative state.⁶⁷ The attending physician contacted Father Phillip Eichner, and informed him that Brother Fox had no reasonable chance of recovery.⁶⁸

Father Eichner requested that the hospital remove the respirator, but the hospital refused to do so without court authorization.⁶⁹ Father Eichner instituted judicial proceedings to be appointed guardian of the person and property of Brother Fox.⁷⁰ During the hearing, the medical evidence established that

59 *Id.* at 93.

60 *See, e.g.,* *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 224 (Cal. Ct. App. 1984); *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1051 (Ohio Ct. App. 1984).

61 *See* *Bartling v. Glendale Adventist Medical Ctr.*, 229 Cal. Rptr. 360, 364-65 (Cal. Ct. App. 1986); *Spring v. Geriatric Auth.*, 475 N.E.2d 727, 732-34 (Mass. 1985); *Leach*, 469 N.E.2d at 1055.

62 *See* *Bartling*, 229 Cal. Rptr. at 365; *Spring*, 475 N.E.2d at 732-34.

63 *See* *Ross v. Hilltop Rehabilitation Hosp.*, 676 F. Supp. 1528, 1530 (D. Colo. 1987) (claims for deprivation of civil rights under 42 U.S.C. § 1983 and discrimination under the Rehabilitation Act, 29 U.S.C. § 794); *Saunders v. State*, 492 N.Y.S.2d 510, 514 (N.Y. Sup. Ct. 1985); *In re Lydia E. Hall Hosp.*, 455 N.Y.S.2d 706 (N.Y. Sup. Ct. 1982).

64 420 N.E.2d 64 (N.Y. 1981).

65 *Id.* at 74.

66 *Id.* at 67.

67 *Id.*

68 *Id.* Brother Fox was a member of a Catholic religious order, the Society of Mary, which operated Chaminade High School in Mineola, NY. Father Eichner was the president of Chaminade and the director of the Society of Mary at the school. *Id.*

69 *Id.*

70 *Id.*

Brother Fox would never recover from the vegetative coma, or regain his cognitive functions.⁷¹

Father Eichner also presented evidence that Brother Fox had made it clear, before his hernia operation, that under these circumstances he would want the respirator removed.⁷² Because of the medical prognosis and the clear evidence which demonstrated that Brother Fox did not want to be maintained in a vegetative coma by use of a respirator, the court allowed Father Eichner to order the withdrawal of the respirator.⁷³

The court of appeals did not recognize that the right of privacy included the right to refuse medical treatment.⁷⁴ The court noted that other states had given the right to refuse medical treatment constitutional protection, but the court did not "reach that question in this case because the relief granted . . . is adequately supported by common-law principles."⁷⁵

2. *In re Storar*⁷⁶

In re Storar was a companion case to *Eichner*, and was also based on common law principles. John Storar was a fifty-two year old mentally retarded resident of a state mental facility. He had a mental age of eighteen months, and had lived in the state facility since he was five.⁷⁷ Doctors discovered that John had cancer of the bladder, and he was admitted to a hospital.⁷⁸ His mother, who was his legal guardian, tried to withdraw consent for life-prolonging blood transfusions.⁷⁹ The New York Court of Appeals ordered the blood transfusions to continue. The court did not use the substituted judgment doctrine because John was never competent; he had never been able to make an informed decision regarding medical treatment.⁸⁰ The court decided that the state's

71 *Id.* at 68.

72 *Id.* In 1976, in the context of a community discussion of the moral implications of the *Quinlan* case, Brother Fox agreed with the New Jersey Supreme Court decision, stating he would not want to be kept alive by extraordinary means under those circumstances. Brother Fox reiterated his position several months before the operation. *Id.*

73 *Id.* at 74. A case that is factually similar to, and follows, *Eichner* is *Leach v. Akron Gen. Medical Ctr.*, 68 Ohio Misc. 1 (C.P. P. Div. 1980).

74 *Id.* at 70.

75 *Id.*

76 420 N.E.2d 64 (N.Y.), *cert. denied*, 454 U.S. 858 (1981).

77 *Id.* at 68.

78 *Id.*

79 *Id.* at 69.

80 *Id.* at 72-74.

parens patriae interest⁸¹ prevailed over Mrs. Storar's attempt to exercise John's common law and constitutional right.⁸² The court of appeals emphasized that prior judicial procedures were optional in New York.⁸³ Doctors and families of an incompetent patient could seek a judicial determination if the legal ramifications of their actions were uncertain.⁸⁴ The court of appeals stated that if it was desirable to expand the judicial role in decisions involving the discontinuance of medical treatment from incompetent patients, the legislature should define the courts' role.⁸⁵

C. Mixed Cases

Some courts have founded the right to refuse medical treatment on both common law principles and constitutional provisions.

The Washington Supreme Court, in *In re Colyer*,⁸⁶ considered the issue of an incompetent patient's right to refuse medical treatment. The court based its decision on the constitutional right of privacy and the common law right to be free from bodily invasions.⁸⁷

Bertha Colyer sustained cardiopulmonary arrest. She was resuscitated, but her body was deprived of oxygen for ten minutes. She entered a persistent vegetative state and was unable to breathe without the assistance of a respirator.⁸⁸

Bertha Colyer's husband was appointed her guardian, and petitioned the superior court to authorize the removal of the respirator.⁸⁹ The superior court granted Mr. Colyer's request, but stayed its order so that the Washington Supreme Court could

81 *Parens patriae* is the principle that the state must care for those who cannot take care of themselves, such as juveniles and the insane. BLACK'S LAW DICTIONARY 1114 (6th ed. 1990).

82 *Storar*, 420 N.E.2d at 73.

83 *Id.* at 74.

84 *Id.*

85 *Id.*

86 660 P.2d 738 (Wash. 1983).

87 *Id.* at 741-43. The court based the right on the state and federal constitutions. The court engaged a question other courts have ignored: does state action exist so that the federal right can be applied against the states through the Fourteenth Amendment? The Washington court found state action in this case. *Id.* at 742. See also *In re Spring*, 405 N.E.2d 115 (Mass. 1980).

88 *Id.* at 740.

89 *Id.*

review the decision.⁹⁰ The Washington Supreme Court upheld the decision because they found no compelling state interest that outweighed Bertha Colyer's right to refuse medical treatment.⁹¹ The court held that judicial intervention in every decision to withdraw life sustaining treatment is not required.⁹² The court adopted procedures similar to those used in *Quinlan*.⁹³ The court noted that this case was factually similar to *Quinlan*, but the court did not abdicate the authority of the courts in this area.⁹⁴ The court suggested that judicial intervention may be required in a case similar to *Saikewicz*.⁹⁵

In cases that require a judicial determination, *Colyer* established that the court's role is to determine if the evidence demonstrates that the patient would have refused treatment if they were competent.⁹⁶

III. STATUTORY ADVANCE DIRECTIVES.

When a person is competent, refusing unwanted medical treatment is fairly simple, but when a person becomes incompetent the exercise of that right becomes problematic. An overwhelming majority of states have enacted statutes that provide a way, or ways, for individuals to plan for medical decision-making should they become incompetent. These statutes are generically known as living will statutes, natural death acts, or durable power of attorney statutes. These statutes provide a mechanism for exercising the right to refuse medical treatment even after an individual has become incompetent.⁹⁷

These statutes authorize individuals to execute advance directives. An advance directive is a "means by which competent indi-

90 *Id.*

91 *Id.* at 744. The court considered four state interests: the preservation of life; the protection of the interests of innocent third parties; the prevention of suicide; and the maintenance of the ethical integrity of the medical profession. *Id.* at 743.

92 *Id.* at 746.

93 *Id.* at 745-46.

94 *Id.* at 746.

95 *Id.*

96 *Id.* at 750-51.

97 In most states the substantive legal basis for the right to refuse treatment is implicit. See MEISEL, *supra* note 9, at 54. Some states, however, explicitly enunciate the substantive rights. See IOWA CODE ANN. § 144A.7 (West Supp. 1991); see also FLA. STAT. ANN. § 765.07 (West 1986); N.M. STAT. ANN. § 24-7-8.1 (1991); N.C. GEN. STAT. § 90-322 (1991); OR. REV. STAT. § 127.635(1) (1990); TEX. HEALTH & SAFETY CODE ANN. § 672.003 (West 1992).

viduals . . . give instructions about their health care that are to be implemented at some later date should they then lack the capacity to make medical decisions."⁹⁸ Living wills and durable power of attorneys for health care are two types of advance directives. Advance directives are intended to provide a means for decision-making for patients who are no longer capable of making their own health care choices.

Advance directives are of enormous value to individuals who want to plan for the future. If a person is competent, they can make their own health care decisions as they are needed. If they want to refuse a particular medical procedure, they can; this right is protected by the common law doctrine of informed consent.⁹⁹ Persons who are incompetent can no longer participate in decisions relating to their own health care.¹⁰⁰ Incompetent patients cannot make health care decisions contemporaneously, but, if their state legislature has enacted a statute allowing advance directives, they can, while competent, make these decisions in advance.¹⁰¹

Although some courts have recognized common law advance directives,¹⁰² one court has held that its state's natural death act preempted common law rights.¹⁰³ In some states the common law regarding advance directives is not developed, or common law advance directives are not recognized.¹⁰⁴ Unless the individual resides in a state where the common law recognizes advance directives, he runs the risk of not having his wishes enforced if he does

98 MEISEL, *supra* note 9, at 312.

99 See *supra* notes 51-63 and accompanying text.

100 See MEISEL, *supra* note 9, at 176 ("The concept of incompetence first distinguishes between those persons who are entitled to exercise decision-making prerogatives and those who are not."); see also RUTH FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 287-88 (1986).

101 State statutes are not the sole means by which an advanced directive can be executed. See MEISEL, *supra* note 9, at 359-60.

102 See, e.g., *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So.2d 921 (Fla. 1984).

103 All but one court that has addressed the issue has concluded that natural death acts do not preempt common law rights to make advance directives. The only court to hold otherwise is the Missouri Supreme Court in *Cruzan v. Harmon*, 760 S.W.2d 408, 425 (Mo. 1988), *aff'd sub nom.*, *Cruzan v. Director, Mo. Dep't of Health*, 110 S.Ct. 2841 (1990). See *infra* note 194 and accompanying text.

104 See *Saunders v. State*, 492 N.Y.S.2d 510 (N.Y. Sup. Ct. 1985) (the court said it could not recognize the validity of a living will without a legislative enactment declaring the directive to be legally binding).

not execute a statutorily authorized advance directive. For this reason statutorily authorized advance directives are superior.

A. Uniform Acts

The National Commissioners on Uniform State Law adopted the Uniform Rights of the Terminally Ill Act¹⁰⁵ in 1985, and several states have adopted it since then.¹⁰⁶ In 1989, the National Commissioners on Uniform State Law approved a completely revised version of the act.¹⁰⁷ When originally proposed, this act was referred to as the Uniform Natural Death Act.¹⁰⁸

The Model Health-Care Consent Act¹⁰⁹ was approved by the National Commissioners on Uniform State Law in 1982. The act is very narrow in scope and is designed only to provide assistance in cases that occur routinely in medical practice.¹¹⁰ The act has been adopted in one state.¹¹¹

Other uniform laws have been proposed, but none have been wholly adopted. In 1982, the legal advisory committee of Concern for Dying drafted the Uniform Right to Refuse Medical Treatment Act.¹¹² The Society for the Right to Die drafted the Medical Treatment Decision Act.¹¹³

105 9B U.L.A. 609 (1987). For a critical analysis of the Uniform Rights of the Terminally Ill Act, see Marguerite A. Chapman, *The Uniform Rights of the Terminally Ill Act: Too Little, Too Late*, 42 ARK. L. REV. 319 (1989); Thomas J. Marzen, *Uniform Rights of the Terminally Ill Act: A Critical Analysis*, 1 ISSUES IN L. & MED. 441 (1986).

106 ALASKA STAT. § 18.12.010 (1991); ARK. CODE ANN. § 20-17-201 (Michie Supp. 1991); IOWA CODE ANN. § 144A.1 (West 1989); MO. ANN. STAT. § 459.010 (Vernon Supp. 1992); MONT. CODE ANN. § 50-9-101 (1991); N.D. CENT. CODE § 23-06.4-01 (1991); OKLA. STAT. ANN. tit. 63, § 3101 (West Supp. 1992).

107 9B U.L.A. 79 (Supp. 1991). This act supercedes the 1985 act. One state, Maine, has adopted the 1989 version of the act. See ME. REV. STAT. ANN. tit. 18-A, § 5-701 (West Supp. 1991).

108 HANDBOOK OF THE NATIONAL CONFERENCE ON UNIFORM STATE LAWS AND PROCEEDINGS OF THE ANNUAL CONFERENCE MEETINGS IN ITS NINETIETH YEAR 66, 76 (1983).

109 9 U.L.A. 453 (1988). For a critical analysis of the Model Health Care Consent Act, see Alexander M. Capron, *Uniform Law Commissioners' Model Health Care Consent Act: Considerations Against Adoption*, 4 J. LEGAL MED. 513 (1983); Theodore R. LeBlang, *Uniform Law Commissioners' Model Health Care Consent Act: An Overview*, 4 J. LEGAL MED. 479 (1983).

110 MODEL HEALTH-CARE CONSENT ACT, 9 U.L.A. 453, 454 (1988).

111 See IND. CODE ANN. § 16-8-12-1 (West 1992).

112 See MEISEL, *supra* note 9, at 336. This act is reprinted in the PRESIDENT'S COMMISSION REPORT, *supra* note 1, at 428.

113 See MEISEL, *supra* note 9, at 336. This act is reprinted in PRESIDENT'S COMMISSION REPORT, *supra* note 1, at 313.

B. *Natural Death Acts.*

A large majority of states have enacted statutes that govern the execution and enforcement of advance directives for decision-making about life-sustaining treatment.¹¹⁴ These acts are generically known as natural death acts and living will statutes. The directives executed pursuant to one of these statutes are often called living wills.¹¹⁵ However, it is important to distinguish between a common law advance directive and a statutorily based advance directive.

Natural death acts serve the same purpose as common law advance directives, but the statute gives the directives a certain legal basis for foregoing life-sustaining treatment. Statutorily based advance directives can be used to refuse or consent to medical treatment in advance.¹¹⁶

Natural death acts are not intended to permit everyone to refuse medical treatment under all circumstances. Most statutes manipulate the definition of three terms—"qualified patient," "terminal condition," and "life-sustaining procedure"—to describe which individuals can execute a statutory advance directive, which types of treatment they can refuse, and under what circumstances these

114 ALA. CODE § 22-8A-1 (1990); ARIZ. REV. STAT. ANN. § 36-3201 (1986); CAL. HEALTH & SAFETY CODE § 7185 (West Supp. 1992); COLO. REV. STAT. ANN. § 15-18-101 (West 1989); CONN. GEN. STAT. ANN. § 19a-570 (West 1991); DEL. CODE ANN. tit. 16 § 2501 (1983); D.C. CODE ANN. § 6-2421 (1989); FLA. STAT. ANN. § 765.01 (West 1986); GA. CODE ANN. § 31-32-1 (1991); HAW. REV. STAT. § 327D-1 (1991); IDAHO CODE § 39-4502 (Supp. 1991); ILL. ANN. STAT. ch. 110 1/2, para. 701 (Smith-Hurd Supp. 1991); IND. CODE ANN. § 16-8-11-1 (West 1992); KAN. STAT. ANN. § 65-28,101 (1985 & Supp. 1990); KY. REV. STAT. ANN. § 311.622 (Baldwin 1991); LA. REV. STAT. ANN. § 40:1299.58.1 (West Supp. 1991); MD. CODE ANN., HEALTH-GEN. § 5-601 (1990); MINN. STAT. ANN. § 145B.01 (West Supp. 1992); MISS. CODE ANN. § 41-41-101 (Supp. 1991); NEV. REV. STAT. ANN. § 449.535 (Michie 1991); N.H. REV. STAT. ANN. § 137-H:1 (Supp. 1991); N.J. STAT. ANN. § 46:2B-8 (West Supp. 1991); N.M. STAT. ANN. § 24-7-1 (Michie 1991); N.C. GEN. STAT. § 90-320 (1990); OR. REV. STAT. § 127.605 (1990); S.C. CODE ANN. § 44-77-10 (Law. Co-op. Supp. 1987); S.D. CODIFIED LAWS ANN. § 34-12D-1 (Supp. 1991); TENN. CODE ANN. § 32-11-101 (Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. § 672.001 (West 1992); UTAH CODE ANN. § 75-2-1101 (Supp. 1991); VT. STAT. ANN. tit. 18, § 5251 (1987); VA. CODE ANN. § 54.1-2981 (Michie 1991); WASH. REV. CODE ANN. § 70.122.010 (Supp. 1991); W. VA. CODE § 16-30-1 (1991); WIS. STAT. ANN. § 154.01 (West 1989); WYO. STAT. § 35-22-101 (1988 & Supp. 1991). See also *supra* notes 106-107.

115 MEISEL, *supra* note 9, at 356.

116 See DEL. CODE ANN. tit. 16, § 2502(c) (1983); IND. CODE ANN. § 16-8-11-10 (West 1992); MD. CODE ANN., HEALTH-GEN. § 5-611 (1990); N.H. REV. STAT. ANN. § 137-H:1 (Supp. 1991); UTAH CODE ANN. § 75-2-1105 (Supp. 1991).

treatments can be refused.¹¹⁷ However, as long as the statute does not preempt common law rights, a person who falls outside of the group described by the statutory definitions may execute an advance directive based on common law rights. The only effect of not falling into the statutorily defined group is that such a person cannot execute an advance directive pursuant to the statute. The statutorily authorized directives are more readily recognized and followed because the statutes make clear the rights and liabilities not only of the patient but also of the health care providers. One case particularly emphasizes the importance of identifying the rights of the patient and the liabilities of the health care providers.

The California courts considered the issues of discontinuing treatment to an incompetent patient in a unique context. In *Barber v. Superior Court*¹¹⁸ two doctors, who had ordered the removal of all life-sustaining equipment and intravenous feeding tubes from a patient in a persistent vegetative state, were charged with murder.¹¹⁹

Mr. Clarence Herbert suffered a cardiorespiratory arrest while recovering from an operation. Mr. Herbert was in a deeply comatose state and was placed on life-support equipment. His chances for recovery were poor.¹²⁰

Mr. Herbert had not executed an advance directive pursuant to California's Natural Death Act.¹²¹ After receiving a written request from Mr. Herbert's family, the two physicians removed the respirator and other life-support equipment.¹²² Mr. Herbert continued to breathe. The physicians consulted with Mr. Herbert's family, and two days after the respirator was removed, the doctors ordered the removal of the intravenous feeding tubes which provided hydration and nourishment.¹²³ Mr. Herbert eventually died.¹²⁴

The two doctors were charged with murder.¹²⁵ A municipal court dismissed the indictment, but the superior court reinstated

117 MEISEL, *supra* note 9, at 366.

118 195 Cal. Rptr. 484 (Cal. Ct. App. 1983).

119 *Id.* at 486.

120 *Id.*

121 CAL. HEALTH & SAFETY CODE § 7185 (West Supp. 1992).

122 195 Cal. Rptr. at 486.

123 *Id.*

124 *Id.*

125 *Id.* The doctors were also charged with conspiracy to commit murder. *Id.*

the charges.¹²⁶ The doctors sought a writ to prohibit the prosecution.

The court of appeals issued the writ and held that the state's natural death act is not the exclusive basis for terminating life-sustaining treatment.¹²⁷ The court of appeals held that the doctors' failure to continue treatment, though intentional and with knowledge that Mr. Herbert would die, was not an unlawful failure to perform a legal duty.¹²⁸ The court concluded that a physician has no duty to continue to treat a patient in a comatose state once the treatment has been proven to be ineffective. Since there is no criminal liability for a failure to act unless there is a legal duty to act, the doctors' conduct was not unlawful.¹²⁹

The court outlined a test for deciding whether a particular treatment is reasonably beneficial to a patient. The determination rests upon whether the treatment is proportionate or disproportionate in terms of the benefits gained versus the burdens caused.¹³⁰ A proportionate treatment is a treatment that has at least a reasonable chance of providing benefits to the patient, and the benefits outweigh the burdens attendant to the treatment.¹³¹ In *Barber*, the court ruled that the doctors' conduct was lawful because the benefits provided by the intravenous treatment were disproportionately small as compared to the expected burdens.¹³²

The court also addressed the question of who should make this vital determination.¹³³ The court concluded that the medical diagnoses and prognoses must be made by the treating physician under the generally accepted standards of medical practice in the community, and, whenever possible, the patient himself should then make the ultimate decision.¹³⁴ If the patient is incompetent, the court held that a court appointed surrogate decision-maker or the patient's immediate family, in consultation with the attending physician, may authorize the removal of life-sustaining treatment.¹³⁵

126 *Id.*

127 *Id.* at 490.

128 *Id.* at 493-94.

129 *Id.* at 490-91.

130 *Id.* at 491.

131 *Id.*

132 *Id.* at 491-92.

133 *Id.* at 492.

134 *Id.*

135 *Id.* at 494.

The *Barber* court further noted that any surrogate decision-maker should be guided by their knowledge of the patient's desires and feelings, if they were expressed before the patient became incompetent. If the patient's desires are unascertainable, the surrogate should base her decision on the patient's best interests.¹³⁶ The court held that judicial approval is not necessary before decisions to withdraw medical treatment are made.¹³⁷

The court concluded that Mr. Herbert's family, in conjunction with the attending physicians, were the proper decision-makers. There was evidence that Mr. Herbert had expressed to his wife, before he became incapacitated, that he would not want to be kept alive by machines.¹³⁸ Therefore, the doctors' omission to continue treatment under the circumstances was not an unlawful failure to perform a legal duty.¹³⁹

C. *Durable Power of Attorney Statutes.*

A power of attorney is a legal instrument that gives an agent legal authority to act on behalf of the principal. Authority to act under a common law power of attorney terminates when the principal becomes incompetent.¹⁴⁰ This limitation makes the common law power of attorney useless as a tool to plan for loss of competency.

Today all states have durable power of attorney statutes,¹⁴¹ and many are modeled after the Uniform Durable Power of Attorney Act.¹⁴² Durable power of attorney statutes provide an alternative to court-ordered, protective procedures,¹⁴³ like guardianship, to deal with an individual's financial affairs. Durable power statutes were not originally designed to deal with personal care decisions.¹⁴⁴ However, there is no reason why a durable power of attorney cannot be used for such matters.¹⁴⁵

136 *Id.* at 493. This is significant because the court endorses two standards for making this decision. If the incompetent patient's desires are ascertainable, the court advocates using the "substituted judgment" approach. See *supra* note 33. If the patient's desires are not ascertainable, the court advocates using the "best interests of the patient" standard.

137 *Id.*

138 *Id.*

139 *Id.*

140 RESTATEMENT (SECOND) OF AGENCY §§ 120, 122 (1957).

141 See *Saunders v. State*, 492 N.Y.S.2d 510, 516 (N.Y. Sup. Ct. 1985).

142 8A U.L.A. 275 (1983).

143 *Id.* at 276.

144 MEISEL, *supra* note 9, at 331.

145 See Mark Fowler, Note, *Appointing An Agent to Make Medical Treatment Choices*, 84

A rapidly increasing number of states have enacted statutes that expressly provide for health care durable powers of attorney.¹⁴⁶ Some health care power of attorney statutes deal exclusively with health care decisions, while others have a specific health care provision in their general durable power of attorney statute. In a few states, the general durable power of attorney statutes do not mention health care decision-making, but they can be used to appoint health care agents because separate, and more recent, statutes specifically authorize such use.¹⁴⁷

IV. THE LEGISLATIVE RESPONSE.

This Part will focus on problems that arose and questions that were left open when state legislatures enacted statutes creating mechanisms to exercise the right to refuse medical treatment. In general, action by state legislatures has added a measure of certainty to this unsettled area of law. However, their efforts have generated new questions and ignored old issues.

COLUM. L. REV. 985 (1984).

146 ALASKA STAT. § 13.26.332 (Supp. 1991); ARIZ. REV. STAT. ANN. § 36-3201 (Supp. 1991) (as interpreted by *Rasmussen v. Flemming*, 741 P.2d 674 (Ariz. 1987)); ARK. STAT. ANN. § 20-17-202(b) (Supp. 1991); CAL. CIV. CODE § 2430 (West Supp. 1992); COLO. REV. STAT. ANN. § 15-14-501 (West 1989); CONN. GEN. STAT. ANN. § 1-43 (West Supp. 1991); DEL. CODE ANN. tit. 16, § 2502(b) (1983); D.C. CODE ANN. § 21-2205 (1989); FLA. STAT. ANN. § 709.08 (Supp. 1991); GA. CODE ANN. § 31-36-1 (1991); HAW. REV. STAT. § 327D-26(1) (1991); IDAHO CODE § 39-4505 (Supp. 1991); ILL. ANN. STAT. ch. 100 1/2, para. 804-1 (Smith-Hurd Supp. 1991); IND. CODE ANN. § 16-8-12-6 (West 1992); IOWA CODE ANN. § 633.705 (West Supp. 1991); KAN. STAT. ANN. § 58-625 (Supp. 1990); KY. REV. STAT. ANN. § 311.970 (Baldwin 1991); LA. REV. STAT. ANN. § 40:1299.58.3(C)(1) (West Supp. 1991); ME. REV. STAT. ANN. tit. 18-A, § 5-501 (West Supp. 1991); MD. CODE ANN., EST. & TRUSTS § 13-601 (1991); MASS. ANN. LAWS ch. 201D, § 1 (Law. Co-op. Supp. 1991); MINN. STAT. ANN. § 145B.06.2 (West Supp. 1992); MISS. CODE ANN. § 41-41-151 (Supp. 1991); NEV. REV. STAT. ANN. § 449.800 (Michie 1991); N.J. STAT. ANN. § 46:2B-8 (West 1989) (as interpreted by *In re Peter*, 529 A.2d 419 (N.J. 1987)); N.M. STAT. ANN. § 45-5-501 (Michie 1989); N.Y. PUB. HEALTH LAW § 2980 (McKinney Supp. 1992); N.C. GEN. STAT. § 32A-2(9) (1991); OHIO REV. CODE ANN. § 1337.11 (Anderson Supp. 1990); OR. REV. STAT. § 127.505 (1990); PA. STAT. ANN. tit. 20, § 5604 (Supp. 1991); R.I. GEN. LAWS § 23-4.10-1 (1989); S.C. CODE ANN. § 65-5-501 (Law. Co-op. Supp. 1991); S.D. CODIFIED LAWS ANN. § 59-7-2.1 (1978); TENN. CODE ANN. § 34-6-201 (1991); TEX. CIV. PRAC. & REM. CODE ANN. § 135.001 (West 1992); UTAH CODE ANN. § 75-2-1106 (Supp. 1991); VT. STAT. ANN. tit. 14, § 3451 (1989); VA. CODE ANN. § 11-9.1 (Michie 1989); WASH. REV. CODE ANN. § 11.94.010 (West 1987); W. VA. CODE § 16-30A-1 (1991); WIS. STAT. ANN. § 155.01 (West Supp. 1991); WYO. STAT. § 35-22-102(d) (1988).

147 Usually, durable power of attorney statutes combine with living will statutes (see, e.g., IND. CODE ANN. §§ 16-8-11-1, 16-8-12-6 (West 1992)) or surrogate decision-making statutes (see, e.g., IOWA CODE ANN. §§ 144A.7.1, 633.705 (West Supp. 1991); MD. CODE ANN., EST. & TRUSTS §§ 13-601, 13-602 (1990); MD. CODE ANN., HEALTH-GEN. § 20-107(d) (1990); VA. CODE ANN. §§ 11-9.1, 37.1-134.4.B (1989)) to reach this result.

A. *Who can refuse medical treatment?*

The first issue this Note addresses is who has the right to refuse what medical treatment under the statutes and when. This is really an old issue that the legislatures ignored and not a new question generated by the statutes. In most of the living will statutes the answer to this question lies in the statutory definitions of "qualified patient," "terminal condition," and "life-sustaining procedure."¹⁴⁸

The focus of this question is who is excluded from the group described in the statutory definitions. This Note evaluates the state statutes by looking for the answer to one of the most troubling questions in this area of the law: can an incompetent person, who is in a persistent vegetative state, refuse artificial nutrition and hydration in advance pursuant to the state statute?

1. The Uniform Rights of the Terminally Ill Act (URTIA)¹⁴⁹

The definitions in the URTIA are typical of those found in state statutes,¹⁵⁰ however there are substantial differences in some states. The definitions of "life-sustaining treatment,"¹⁵¹ "qualified patient,"¹⁵² and "terminal condition"¹⁵³ are interrelated. To determine the definition of "terminal condition," we must replace the term "life-sustaining treatment" with its definition. To determine who is a "qualified patient," we must substitute the definition of "terminal condition" for the term "terminal condition." This produces: a qualified patient is a patient who is at least eighteen years old, who has executed a declaration, and who has been determined by his attending physician to have an incurable or irreversible condition, that without the administration of a

148 See *supra* note 117 and accompanying text.

149 9B U.L.A. 609 (1987).

150 The 1985 URTIA was based upon existing legislation. See 9B U.L.A. 609 (1987) (prefatory note). Eight states have adopted either the 1985 or 1989 version of the URTIA. *Id.* The definitions in both versions of the URTIA are the same. *Id.*

151 "Life-sustaining treatment" means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying. UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 1(3), 9B U.L.A. 611 (1987).

152 "Qualified patient" means a patient [18] or more years of age who has executed a declaration and who has been determined by the attending physician to be in a terminal condition. *Id.* at § 1(7).

153 "Terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining treatment, will in the opinion of the attending physician, result in death within a relatively short time. *Id.* at § 1(9).

medical procedure or intervention which will only prolong the process of dying, will, in the opinion of his physician, result in death within a relatively short time.

Can an incompetent patient refuse artificial nutrition and hydration under this statute? If the patient is at least eighteen years old and has executed an advance directive, he might be able to. The incompetent patient can refuse artificial nutrition and hydration only if providing artificial nutrition and hydration is considered life-sustaining treatment; however, the URTIA, like most state statutes, is not clear about whether artificial nutrition and hydration is a life-sustaining treatment.

2. States which allow refusal of artificial nutrition and hydration.

Some states specifically allow individuals to refuse artificial nutrition and hydration.¹⁵⁴ The Alaska Rights of the Terminally Ill Act specifically states that "[t]he declaration may provide that the declarant does not want nutrition or hydration administered intravenously or by gastric tube."¹⁵⁵ The Colorado Medical Treatment Decision Act states that a declaration can, in the event that the only procedure being provided is artificial nutrition, direct the artificial nourishment not be continued, be provided only for a specified period of time, or that the artificial nutrition be continued.¹⁵⁶

The Minnesota Adult Care Decisions Act provides that a declaration "must state the declarant's preferences regarding whether the declarant wishes to receive or not receive artificial administration of nutrition and hydration" or appoint a proxy to make this decision.¹⁵⁷ The Idaho Natural Death Act provides a statutory living will; in paragraph one of the suggested living will form,

154 See ALASKA STAT. § 18.12.010 (1991); ARIZ. REV. STAT. ANN. § 36-3202 (Supp. 1991); COLO. REV. STAT. ANN. § 15-18-101 (West 1989); IDAHO CODE § 39-4502 (Supp. 1991); ME. REV. STAT. ANN. tit. 18-A, § 5-701(b)(4) (West Supp. 1991); MINN. STAT. ANN. § 145B.01 (West Supp. 1992).

155 ALASKA STAT. § 18.12.040(b) (1991).

156 COLO. REV. STAT. ANN. § 15-18-104(2.5)(a) (West Supp. 1991). The statute also says that when an attending physician determines that pain results from the discontinuation of artificial nourishment, the doctor may order that nourishment be provided to the extent necessary to provide comfort and alleviate pain. COLO. REV. STAT. ANN. § 15-18-104(2.6) (West Supp. 1991).

157 MINN. STAT. ANN. § 145B.03(2)(b) (West Supp. 1992).

declarants are given the choice of accepting or rejecting artificial nutrition and hydration by checking a box.¹⁵⁸

3. States which do not allow refusal of artificial nutrition and hydration.

Some states specifically prohibit directives that would instruct health care providers to forego artificial nutrition and hydration.¹⁵⁹ However, it is important to realize that if the statute does not preempt common law rights, a directive made pursuant to common law doctrines, and not the statute, may be enforceable.¹⁶⁰

4. States where it is uncertain if you can refuse artificial nutrition and hydration.

Some statutes are not clear about whether their statutorily authorized advanced directives allow for refusal of artificial nutrition and hydration. Many states have merely adopted the definitions from the URTIA¹⁶¹ exactly, or with alterations not relevant here. The URTIA states that its provisions do not affect the responsibility of providing artificial nutrition and hydration.¹⁶² Since the statute does not address this issue, one must search through court decisions in a jurisdiction to see if the courts have addressed it.

In other states the legislature has failed to coordinate the various "right to die" statutes. This failure has generated uncertainty. The Indiana Living Wills and Life-Prolonging Procedures Act clearly states that artificial nutrition and hydration is not a life-

158 IDAHO CODE § 39-4504 (Supp. 1991).

159 ARIZ. REV. STAT. ANN. § 36-3201(4) (1986); ARK. CODE ANN. § 20-17-206(b) (Michie Supp. 1991); CONN. GEN. STAT. ANN. § 19a-570(1) (West 1991); FLA. STAT. ANN. § 765.03(3) (West 1986); GA. CODE ANN. § 31-32-2(5)(a) (1991); HAW. REV. STAT. § 327D-2 (1991); ILL. ANN. STAT. ch. 110 1/2, § 702(2)(d) (Smith-Hurd Supp. 1991); IND. CODE ANN. § 16-8-11-4 (West 1992); IOWA CODE ANN. § 144A.2(5) (West 1989); MD. CODE ANN., HEALTH-GEN. § 5-605(1) (1990); MO. ANN. STAT. § 459.010(3) (Vernon Supp. 1992); MONT. CODE ANN. § 50-9-202(2) (1991); N.H. REV. STAT. ANN. § 137-H:2 (Supp. 1991); OKLA. STAT. ANN. tit. 63, § 3102(4) (West Supp. 1992); OR. REV. STAT. § 127.605(3) (1990); S.C. CODE ANN. § 44-77-20(2) (Law. Co-op. Supp. 1990); UTAH CODE ANN. § 75-2-1103(6)(b) (Supp. 1991); WISC. STAT. ANN. § 154.01(5) (West 1989); WYO. STAT. § 35-22-101(a) (1988 & Supp. 1991). *See also* OHIO REV. CODE ANN. § 1337.13(E) (Anderson Supp. 1990) (health care durable power of attorney statute prohibits the refusal of artificial nutrition and hydration unless certain conditions are met).

160 *See supra* notes 51-63 and accompanying text.

161 *See supra* notes 151-53 and accompanying text.

162 UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 6(b), 9B U.L.A. 609, 617 (1987).

prolonging procedure which can be refused in a statutory living will.¹⁶³ The Indiana Health Care Consent Act¹⁶⁴ allows adults to appoint health care representatives to consent, on their behalf, to health care if the appointor becomes incompetent. The appointors can give their health care representatives instruction regarding which procedures to accept and which to refuse, and under what circumstances.¹⁶⁵ Unfortunately, the definition of health care in the Health Care Consent Act is silent as to whether artificial nutrition and hydration are included in or excluded from the types of treatment that may be refused by the representative.¹⁶⁶

This could mean that the state legislature intended to allow its adult citizens to refuse artificial nutrition and hydration by appointing a health care representative, but not by executing a living will. Although this is not a logical proposition, if the legislature wanted to exclude administration of artificial nutrition and hydration from the definition of "health care" in the Health Care Consent Act, all it had to do was say: "health care has the same meaning set forth in IC 16-8-11-5."¹⁶⁷ The only logical inference is that the legislature did not intend the definitions to be the same. This leads to the absurd result that one can refuse artificial nutrition and hydration by appointing a health care agent, but not by executing a living will.¹⁶⁸ However, this is the law in Indiana after the Indiana Supreme Court's decision in *In the Matter of Sue Ann Lawrance*.¹⁶⁹

Sue Ann Lawrance was a forty-two year old woman who was in a persistent vegetative state for over four years.¹⁷⁰ Sue Ann's parents sought to discontinue her artificially provided nutrition and

163 IND. CODE ANN. § 16-8-11-4 (West 1992). The definition of life-prolonging procedure specifically excludes artificial nutrition and hydration.

164 IND. CODE ANN. § 16-8-12-1 (West 1992).

165 *Id.* at § 16-8-12-6(d).

166 *Id.* at § 16-8-12-1(2).

167 In fact, the legislature showed it was familiar with this technique in the definition of "health care provider" in the Health Care Consent Act. *See Id.* at § 16-8-12-1(3).

168 The statute itself resolves the argument that the definition of health care in the Health Care Consent Act reflects a change in policy, and that the legislature intended to allow refusal of artificial nutrition and hydration by using either a living will or a health care agent. The Health Care Consent Act states that it does not affect Indiana law concerning an individual's authorization to make a health care decision for himself, or another, or to provide, withdraw, or withhold medical care necessary to prolong or sustain life. *See Id.* at § 16-8-12-11(a).

169 579 N.E.2d 32 (Ind. 1991).

170 *Id.* at 34.

hydration.¹⁷¹ Sue Ann had suffered permanent brain damage as a child; she was never competent to make her own health care decisions.¹⁷²

The Indiana Supreme Court faced the issue of whether the Indiana Health Care Consent Act applied where the family of a never-competent patient in a persistent vegetative state sought to withdraw the patient's artificially provided nutrition and hydration.¹⁷³ The main question was whether artificial nutrition and hydration falls within the definition of health care found in the Health Care Consent Act.

The court noted that artificial nutrition and hydration is not included in or excluded from the definition of health care in the Health Care Consent Act.¹⁷⁴ The court decided that the legislature intended the act to be a procedural statute which did not affect the substantive rights of Indiana citizens.¹⁷⁵ The court then reviewed Indiana common law and statutory law to determine if the right to refuse medical treatment is a substantive right in Indiana.¹⁷⁶ The court decided that it was, and then addressed the question of whether artificial nutrition and hydration falls within the definition of such treatment.¹⁷⁷ Based on the view of the Indiana medical community, statutory law,¹⁷⁸ and court decisions from other jurisdictions, the court decided that artificial nutrition and hydration is medical treatment which can be refused.¹⁷⁹

Following the *Laurance* decision, Indiana residents can refuse artificial nutrition and hydration if they appoint a health care agent pursuant to the Indiana Health Care Consent Act. However,

171 *Id.* at 35.

172 *Id.*

173 *Id.* at 37.

174 *Id.* at 38.

175 *Id.*

176 *Id.* at 38-39.

177 *Id.* at 39.

178 The court seemed to ignore the clear position the Indiana legislature took on this issue in the Indiana Living Wills and Life-Prolonging Procedures Act. The legislature explicitly excluded artificial nutrition and hydration from the definition of life-prolonging procedure. See IND. CODE ANN. § 16-8-11-4 (West 1992). Moreover, the Indiana legislature has reiterated its position since the *Laurance* decision. On January 22, 1992, the Indiana House of Representatives defeated a bill which would have allowed Indiana citizens to use a living will to request a doctor to withhold artificial nutrition and hydration if they were diagnosed with a terminal illness or in a persistent vegetative state. Susan Dillman, *Living Wills Bill Seen Lost To Lobbying*, S. BEND TRIB., Jan. 23, 1992, at C2.

179 *Laurance*, 579 N.E.2d at 39.

Indiana residents cannot refuse artificial nutrition and hydration by executing a living will because the Indiana Living Will Act explicitly excludes the provision of nutrition and hydration from the act's definition of life-prolonging procedures which can be refused.¹⁸⁰

The Tennessee Right to Natural Death Act¹⁸¹ and the Oklahoma Natural Death Act¹⁸² present another peculiar exercise in statutory construction. Both statutes define "medical care"¹⁸³ in a way that may mean a qualified patient can refuse some kinds of artificial nutrition and hydration by advanced directive, but not others. In Tennessee, "medical care" expressly includes artificial or forced feeding, and medical care can be refused, but the definition also states: "[i]n no case shall this section be interpreted to allow the withholding of *simple* nourishment or fluids so as to condone death by starvation or dehydration."¹⁸⁴ This section may mean that a qualified patient can direct the withholding of artificial nutrition and hydration provided by intrusive medical procedures, such as a jejunostomy tube,¹⁸⁵ but the declarant cannot direct the withholding of ordinary oral feeding that includes no medical procedures. Whether the statute would permit foregoing of other, less intrusive procedures, such as an intravenous drip or nasogastric tube, is not clear.¹⁸⁶

B. Are statutes which authorize the use of an advance directive the exclusive method for refusing medical treatment?

The previous section considered the question of who is a qualified patient under natural death acts. In some states, incom-

180 The court tried to explain this disparity in a footnote: "Enacted two years later [than the Living Will Act], the H[ealth] C[are] C[onsent] A[ct] contained no such exclusion, suggesting that the legislature never intended to exclude artificial nutrition and hydration from the HCCA's definition of health care." *Id.* at 40, n. 5.

181 TENN. CODE ANN. § 32-11-101 (Supp. 1991).

182 OKLA. STAT. ANN. tit. 63, § 3101 (Supp. 1991).

183 Oklahoma uses the term "life-sustaining procedure". OKLA. STAT. ANN. tit. 63, § 3102(4) (Supp. 1991).

184 TENN. CODE ANN. § 32-11-103(5) (Supp. 1991) (emphasis added).

185 A jejunostomy tube is a method of providing artificial nutrition and hydration. An opening through the abdominal wall into the jejunum is surgically created and a tube is inserted. Nutrition and hydration are fed into the patient through this tube.

186 See MEISEL, *supra* note 9, at 370. Oklahoma's statute states: "Life-sustaining procedure shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain nor the *normal* consumption of food and water." OKLA. STAT. ANN. tit. 63, § 3102(4) (Supp. 1991) (emphasis added). The interpretation of "normal" consumption raises the same issue as the Tennessee statute.

petent patients can refuse artificial nutrition and hydration, while in other states they cannot; some states' statutes are unclear. This section considers whether individuals who want to plan their medical affairs in case of later incompetency have alternatives if their state statutes prohibit the use of living wills as a means to refuse artificial nutrition and hydration. This question can be restated as: Are natural death acts, living will acts, and durable power of attorney statutes the exclusive source of the right to refuse medical treatment?

Part II of this Note discusses the three bases for the right to refuse medical treatment: the constitutional right of privacy, the common law doctrine of informed consent, and state statutes.¹⁸⁷ Do state statutes preempt the other bases? Clearly a state statute cannot preempt rights protected by the state constitution without a compelling state interest.¹⁸⁸ However, relatively few states have found the right to refuse medical treatment protected under their state constitution.¹⁸⁹ The more troubling question is: Do statutory rights preempt common law rights? The answer differs from state to state.

The URTIA says that the act does not supercede common law rights.¹⁹⁰ All of the states that have adopted the URTIA use this language.¹⁹¹ Some statutes not modeled after the URTIA clearly state that the statute does not affect common law rights.¹⁹²

Some statutes do not address this issue.¹⁹³ In so doing, the

187 See *supra* notes 19-51 and accompanying text.

188 See *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976) ("We think that the state's interest [in favor of prolonging life] weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest.").

189 See *supra* note 22.

190 UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1985) § 10(e), 9B U.L.A. 609, 621 (1987). See also UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989) § 11(e), 9B U.L.A. 609 (Supp. 1991) ("This act does not impair or supercede any right or responsibility that a person has to effect the withholding or withdrawal of medical care.").

191 See ALASKA STAT. § 18.12.080 (1991); ARK. CODE ANN. § 20-17-210(e) (Supp. 1991); IOWA CODE ANN. § 144A.11 (West 1989); ME. REV. STAT. ANN. tit. 18-A, § 5-711(e) (West Supp. 1991); MO. ANN. STAT. § 459.055(2) (Vernon Supp. 1992); MONT. CODE ANN. § 50-9-205(5) (1991); N.D. CENT. CODE § 23-06.4-11.5 (1991); OKLA. STAT. ANN. tit. 63, § 3110(b) (West Supp. 1992).

192 See, e.g., ALA. CODE § 22-8A-9(d) (1990); CAL. HEALTH & SAFETY CODE § 7193 (West Supp. 1992); D.C. CODE ANN. § 6-2429(a) (1989); FLA. STAT. ANN. § 765.15 (West 1991); GA. CODE ANN. § 31-32-11 (1991); MD. CODE ANN., HEALTH-GEN. § 5-610(1) (1990); N.H. REV. STAT. ANN. § 137-H:12 (Supp. 1991); TENN. CODE ANN. § 32-11-110(d) (Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. § 672.021 (West 1992); UTAH CODE ANN. § 75-2-1117(4) (Supp. 1991).

193 See, e.g., ARIZ. REV. STAT. ANN. § 36-3201 (1986); CONN. GEN. STAT. ANN. § 19a-

legislatures have left the question open for judicial construction. Most courts have held that natural death acts do not preempt common law rights or state constitutional rights to refuse medical treatment.¹⁹⁴

In *Cruzan v. Harmon*,¹⁹⁵ the Missouri Supreme Court's discussion of the relationship between its living will statute and common law principles illustrates the complexity of the issue.¹⁹⁶ The court stated: "We intend no judgment here as to whether the common law right to refuse medical treatment is broader than the Living Will statute."¹⁹⁷ However, the court also said

[a]ssuming, *arguendo*, that the right of privacy may be exercised by a third party in the absence of strict formalities assigning that right, the risk of arbitrary decisionmaking and grave consequences attaches all the more when the third party seeks to cause the death of an incompetent . . . no person can assume that choice for an incompetent in the absence of the formalities under Missouri's Living Will Statutes or the clear and convincing, inherently reliable evidence absent here.¹⁹⁸

The court seems to say that even though the common law right to refuse medical treatment may allow third parties to refuse medical treatment on behalf of another, if the patient is incompetent, a third party can refuse medical treatment on the patient's behalf only if the patient has executed a living will, or if there is clear and convincing evidence that the patient would refuse such treatment.

The Missouri Rights of the Terminally Ill Act,¹⁹⁹ which provides the statutory basis for living wills, specifically prevents

570 (West 1991); WASH. REV. CODE ANN. § 70.122.010 (Supp. 1991).

194 *In re Grant*, 747 P.2d 445 (Wash. 1987), *modified*, 757 P.2d 534 (1988). *Cf.* *McConnell v. Beverly Enterprises-Connecticut, Inc.*, 553 A.2d 596, 602 (Conn. 1989) ("When the legislature has attempted to respond to this urgent request for statutory assistance, we have an obligation to pursue the applicability of statutory criteria before resorting to an exploration of residual common law rights, if any such rights indeed remain."); *compare* *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Cal. Ct. App. 1983) and *Corbett v. D'Alessandro*, 487 So.2d 368 (Fla. Dist. Ct. App. 1986) with *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom.*, *Cruzan v. Director, Mo. Dep't of Health*, 110 S.Ct. 2841 (1990).

195 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom.*, *Cruzan v. Director, Mo. Dep't of Health*, 110 S.Ct. 2841 (1990).

196 Missouri's Rights of the Terminally Ill Act did not apply in this case; the statute took effect after Nancy Cruzan's car accident. *Id.* at 420.

197 *Id.*

198 *Id.* at 425.

199 MO. ANN. STAT. § 459.010 (Vernon Supp. 1992).

declarants from directing the withholding or withdrawal of artificial nutrition or hydration.²⁰⁰ Therefore, the only way for a person, planning for future incompetence, to refuse artificial nutrition and hydration is by meeting the clear and convincing evidence standard.²⁰¹

This is not the same as saying that the common law rights are only enforceable through the Rights of the Terminally Ill Act. However, incompetent patients can only exercise their rights through the act or by satisfying a heightened evidentiary standard. The court announced that the clear and convincing evidence standard applied to cases involving the right to refuse medical treatment in *Cruzan*;²⁰² the application of this standard to such issues has no precedential basis. Further, the court considered the Rights of the Terminally Ill Act "an expression of the policy of this state with regard to the sanctity of life."²⁰³ A fair interpretation of this result is that the court curtailed the common law right in the case of incompetent patients because of the State's strong interest in life. The common law rights are barely broader than the statutory rights; an incompetent patient's right to refuse medical treatment can only be exercised on the basis of compliance with the statute or if there is clear and convincing evidence of the patient's wishes.

In order to eliminate the confusion illustrated in *Cruzan v. Harmon*, state legislatures should clarify the relationship between the rights afforded by statute and common law rights. The easiest way for state legislatures to do this is to include a section in the statute which unambiguously states the relationship of the statutorily created rights and the common law of the state.²⁰⁴

200 See MO. ANN. STAT. § 459.010(3) (Vernon Supp. 1992) ("Death-prolonging procedure shall not include . . . the performance of any procedure to provide nutrition or hydration."). A declarant can only direct the withholding or withdrawal of death-prolonging procedures. See MO. ANN. STAT. § 459.015 (Vernon Supp. 1992).

201 This standard is not an unconstitutional obstacle to the exercise of a constitutionally protected right. *Cruzan v. Director, Mo. Dep't of Health*, 110 S.Ct. 2841 (1990).

202 *Cruzan*, 760 S.W.2d at 425.

203 *Cruzan*, 760 S.W.2d at 420. See also *Id.* at 421 ("Missouri's statute, . . . is modeled after URITA [sic], but with substantial modifications which reflect this State's strong interest in life.").

204 See, e.g., IOWA CODE ANN. § 144A.11.5 (West 1989) ("This chapter shall not be interpreted to increase or decrease the right of a patient to make decisions regarding use of life-sustaining procedures as long as the patient is able to do so, nor to impair or supercede any right or responsibility that any person has to effect the withholding or withdrawal of medical care in any lawful manner. In that respect, the provisions of this chapter are cumulative.").

C. Do states enforce statutory advance directives executed in other states?

Even if an advance directive is valid and enforceable in the state where it is executed, the declarant may be outside of that jurisdiction when the directive needs to be enforced. The declarant might move to another state following the execution of the advance directive. One would hope that an individual, who is conscientious enough to meet the statutory requirements in one state, would be conscientious enough to reexecute the directive in compliance with the laws of his new home. However, a declarant may simply be driving through or visiting a foreign jurisdiction when a tragedy occurs.

What can the declarant do to ensure that his wishes will be observed in a foreign state? First, a declarant can include a provision which states that the directive is intended to be enforceable in all jurisdictions, not just his home state. Second, the declarant should try to comply with the formalities of execution for the most stringent American jurisdiction.²⁰⁵ With these exceptions, there is very little individuals can do to guarantee that their directive will be honored unless the state legislature, in the state where the directive is to be enforced, has addressed this question.

Statutes which authorize the execution of advance directives should explicitly state whether or not this state will recognize and enforce directives executed in another state. Some states, but very few, have addressed this question.²⁰⁶

The URTIA provides that declarations executed in another state in compliance with the law of that state or with the law of this state are validly executed.²⁰⁷ Six of the eight jurisdictions that have adopted one of the versions of the URTIA provide for declarations executed in a foreign jurisdiction.²⁰⁸ Two states

205 See MEISEL, *supra* note 9, at 394.

206 See *infra* note 207 and accompanying text.

207 UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1985) § 12, 9B U.L.A. 609, 621 (1987). See also UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989) § 13, 9B U.L.A. 609 (Supp. 1991).

208 See ALASKA STAT. § 18.12.090 (1991); ARK. CODE ANN. § 20-17-212 (Michie Supp. 1991); ME. REV. STAT. ANN. tit. 18-A, § 5-713 (West Supp. 1991); MONT. CODE ANN. § 50-9-111 (1991); N.D. CENT. CODE § 23-06.4-13 (1991); OKLA. STAT. ANN. tit. 63, § 3103.1 (West Supp. 1992). Some of these states require that execution comport with its law; others require execution to comply with its law or the law of the state in which it was executed.

which adopted the URTIA²⁰⁹ did not adopt the URTIA provision regarding foreign directives; presumably, these states chose not to recognize foreign declarations.

At least three states,²¹⁰ which have natural death legislation but did not adopt the URTIA, have included a provision allowing foreign directives to be effective if they meet their statutory requirements, or the requirements of the state of execution.

State legislatures should adopt a provision which would allow foreign directives to be enforced in their state. The purposes of the statutory formalities can be met this way, while respecting the wishes of the declarant.

V. CONCLUSION.

The decision to consent or not consent to life-sustaining treatment is a right of the terminally ill patient. The vast majority of state legislatures have recognized this right, and have enacted legislation which provides for an enforceable method to exercise it. Further legislative action is needed for two reasons: First, courts in those states without living will statutes may not respect a patient's treatment decisions without legislative guidelines;²¹¹ second, patients in states with living will statutes may not have their decisions carried out because of definitional gaps created by poor drafting.

The goal of each state legislature should be to enact laws that will clarify the rights of patients and set forth procedures to exercise these rights. The legislatures should measure their success by the number of families that have to go through painful and expensive court proceedings to have the wishes of a family member honored. The standard to determine success should be high; if even one person has to go through the judicial process because the legislature did not act, or acted carelessly, the legislature has failed.

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209 Iowa and Missouri.

210 See ARIZ. REV. STAT. ANN. § 36-3211 (Supp. 1991); FLA. STAT. ANN. § 765.17 (West Supp. 1991); MD. CODE ANN., HEALTH-GEN. § 5-612 (1990).

211 This issue should be addressed by the legislature rather than the courts. See Bernard K. Freamon, *Death With Dignity Laws: A Plea For Uniform Legislation*, 5 SETON HALL LEGIS. J. 105 (1982).